original 11/28/10 Revised 12/6/10 revised 1/18/11

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0007	A. BUILDING _____ B. WING _____	10/28/2010

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L' ARCHE	2474 ONTARIO RD, NW WASHINGTON, DC 20009

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R 000	INITIAL COMMENTS A licensure survey was conducted on October 27, 2009 through October 28, 2010. A random sample of three residents was selected from a resident population of two women and four men with various disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including incident reports.	R 000	Received 1/18/11 Sm	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records and interview, the agency failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for one of the fifteen (15) staff employed. (Staff #15) The findings include: On October 28, 2010, beginning at approximately 10:30 a.m., review of the personnel records revealed Direct Care (Staff #15) had no documented evidence of a comprehensive criminal background check on file for review. The Program Director and the qualified mentally	R 125	4701.5 Staff #15 does have a background check in her files, dated 5/1/06. Somehow during the inspection this was missed. Background checks are completed when new staff arrive, before they work with the people.	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Program Director TITLE (X6) DATE 12/3/10

STATE FORM 6899 WXRL11 If continuation sheet 1 of 2

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R 125	Continued From page 1 retarded professional (QMRP) acknowledged the aforementioned findings at approximately 4:00 p.m. the same day.	R 125		

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I 000	INITIAL COMMENTS A licensure survey was conducted on October 27, 2009 through October 28, 2010. A random sample of three residents was selected from a resident population of two women and four men with various disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including incident reports.	I 000		
I 057	3502.15 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes. This Statute is not met as evidenced by: Based on interview, the facility failed to ensure that menus were written on a weekly basis for six of six residents (Residents #1, #2, #3, #4 #5, and #6). The findings include: Interview with the program director on October 28, 2010 at approximately 4:17 p.m. revealed that they "don't do menus." According to the program director, she trained the staff on each resident's individual diet. Further interview with the program director revealed the direct care staff had been instructed to write down what was served for each meal daily and then forward weekly to the program director for review and follow-up as needed. At the time of the survey, there was no	I 057	3502.15 Starting the week of Jan 3, 2011, menus will be written in advance, weekly.	

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 057	Continued From page 1 documented evidence that menus were written in advance, at least on a weekly basis.	I 057	3504.1 1. Oven was cleaned 11/22/10 and is now on the regular chore chart which is overseen by HLC. 2. This was cleared after deficiency was noted and is now on regular chore chart which is overseen by HLC.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: During the environmental inspection on October 28, 2010, at approximately 2:00 p.m. the following deficiencies were observed: 1. The kitchen oven had excess grease on the inside. The toaster oven had excessive grease and bread crumbs inside it. 2. In bedroom #1 occupied by resident #4, the ceiling fan had dust on it. These deficiencies were acknowledged by the qualified mental retardation professional (QMRP) at approximately 3:00 p.m. the same day.	I 090	3505.4 Resident #1 will be taken down the steps and to the meeting place (see info re changing policy). This was reviewed with the staff 11/23/10. The QA director lives in the house - so he will monitor the practice during fire drills. We did work with the fire department to change policy to allow waiting areas in both front + back - This will be the practice during both drills and actual fires. Regarding staff please re-entering building during a drill someone must re-enter to turn 2 alarms. This is assumed in the policy.	
I 123	3505.4(a)(1) FIRE SAFETY Each GHMRP shall have on the premises the	I 123		

We will work w/ Fire Dept. + Communicate this by 12/31/10. Fire Dept. is not involved in drills.

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I 123	Continued From page 2 following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (1) The instructions and plans that are to be followed in case of fire, explosion, or other emergency; This Statute is not met as evidenced by: Based on observation, record review and Interview, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure instructions and plans that are to be followed in case of fire, explosion, or other emergency was carried out during a fire drill on the day of survey. The finding includes: On October 28, 2010 at approximately 9:00 a.m. one of the group home's core staff informed the surveyor that he was about to conduct a fire drill. The fire alarm was set at approximately 9:02 a.m. At that time, Core Staff #1 was observed taking Resident #1 in his wheel chair out of the group home's back door. The core staff was observed to place the resident on the back porch at the top of the stairs. It should be noted that the other residents (Residents #2, and #5) was escorted by other core staff down the back stairs away from the house. Residents #2 and #5 was observed standing in the back yard near the parked cars. Interview with Core Staff #1 was conducted to ascertain information regarding why Resident #1 was left at the top of the stairs during the fire drill. According to Core	I 123 3509.6 3519.1	3509.6 Personnel Policies All staff listed (except podiatrist) have current PPD tests but not health certificates. The program director erroneously permitted this to happen because over the past years various monitors have asked only for PPD results. All staff involved and podiatrist have been asked to obtain health certificates and these will be in place by 1/15/11. 3519.1 We will integrate into our incident policy by 12/15/10 the need to call + fax DOH in cases of ER visits and other very significant events. The QA Director does most of the reporting so he will ensure the appropriate reports get to DOH HRLA	

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I 123	Continued From page 3 Staff #1, Resident #1 was able to ambulate, but "we don't take him down the stairs unless it's necessary because he has COPD. They let him walk as less as possible." The surveyor requested the GHMRP's Fire Evacuation Plan during the exit held on October 29, 2010. A copy of the GHMRP's policy and procedures was received via fax on November 3, 2010. Review of the policies and procedures entitled "Fire Evacuation Plan Steps" the following instructions revealed "the assembly area monitor and all core persons shall proceed directly to the assembly area located at the corner of Euclid and Ontario Road. At the assembly area, the assembly area monitor will immediately take a count to ensure that everyone is present or accounted for. DO NOT GO BACK INSIDE the house once you are outside." During the fire drill, the residents were not observed to be escorted to Euclid and Ontario Rd. The staff and residents were observed to continue standing in the back yard. Additionally, Core Staff #1 was observed to go back inside of the GHMRP. At the time of the survey, the GHMRP failed to ensure their core staff implemented the Fire Evacuation Plan/Instructions as written in their policies and procedures.	I 123		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206		

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I 206	Continued From page 4 This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have evidence that an annual screening was performed by each employee, as required by this section for 6 of 15 direct care staff and 1 of 3 consultants. (Staff #1, #3, #9, #10, #12, #14 and the podiatrist) The finding includes: On October 28, 2010, at approximately 10:30 a.m., review of the personnel records revealed the GHMRP failed to have evidence of current health certificates on file for (Staff #1, #3, #9, #10, # #12 #14 and the podiatrist. Interview with the residential director during the review confirmed that the health corticates for the aforementioned staff were expired.	I 206		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by:	I 379		

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I 379	Continued From page 5 Based on interview and review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for two of the six residents (Resident#1 and #4) residing in the facility. The finding includes: 1. Review of the GHMRP's incident reports on October 27, 2010 beginning at 9:40 a.m., revealed an incident report dated May 1, 2010 involving Resident #4. According to a form entitled "View Consumer Incident," Resident #4 was noted with dark urine and swelling of his ankles. Further review of the aforementioned form revealed the resident was transported to a local emergency room to also rule-out the possibility of a blood-clot. At the time of the survey, the facility failed to report this incident that substantially interfered with the resident's health and safety to the Department of Health (DOH) within 24 hours. It should be noted that the incident involving Resident #4 was reported to DOH on May 9, 2010, eight (8) days after the incident occurred. 2. On October 27, 2010 at approximately 10:52 a.m., a form entitled "View Consumer Incident Form" was reviewed. According to the report, Resident #1 was involved in another incident on January 6, 2010. Further review of the report revealed the resident had complained of leg pain in his calf. Initially seen by his Primary Care Physician (PCP) on January 4, 2010. On January 6, 2010, Resident #1's pain worsened and was	I 379		

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I 379	Continued From page 6 taken to the emergency room for further evaluation and diagnosed with "Bakers Cysts" (swelling caused by fluid from the knee joint protruding to the back of the knee). The incident involving Resident #1 was reported to DOH on January 11, 2010, five (5) days after the incident occurred. At the time of the survey, the facility failed to report this incident that substantially interfered with the resident's health and safety to the Department of Health (DOH) within 24 hours. 3. Review of the form entitled "View Consumer Incident Forms" on October 27, 2010 at approximately 10:25 a.m., revealed Resident #1 was seen by his PCP on October 23, 2009. The resident had a heart rate of 127, which alarmed the doctor and was instructed to take the resident to the emergency room immediately. The resident was placed on oxygen with discharge instructions to be seen by a Pulmonology for possible oxygen therapy. At the time of the survey, the facility failed to report this incident that substantially interfered with the resident's health and safety to the Department of Health (DOH) within 24 hours.	I 379		
I 431	3521.7(b) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (b) Toileting (including use of equipment); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents	I 431	3521.7 This gentleman independently uses the bathroom and does not always forget to close the door. In order to preserve his independence and keep him assure his privacy we will institute the following	

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I 431	Continued From page 7 were effectively trained in toileting skills, including privacy while using the restroom for one of the five residents (Resident #3) included in the sample. The finding includes: Observation on October 27, 2010, at 9:00 a.m. revealed Resident #3 was sitting on the toilet with the bathroom door open. Interview with staff revealed that the client needed to be reminded to close the bathroom door. There was no evidence that Resident #3 had received effective training to ensure his privacy while using the bathroom.	I 431	program - when staff [illegible] reading to the bathroom they will wait until he enters. If he does not independently shut the door, staff will remind him, but will do it before he begins to use the toilet so that he does not need at all. The training will be "I what do you need to do when you leave the bathroom?"	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter for one of the residents (Resident #1) included in the sample. The finding includes: Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt and adequate medical attention, as evidenced below:	I 500	3523.1 It appears that the deficiency is connecting discrepancies in AM with [illegible] in PM, and concern with not providing prompt medical attention.	

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I 500	Continued From page 8 1. Review of the GHMRP's unusual incident reports/investigations on October 27, 2010 beginning at 9:40 a.m., revealed an internal investigation dated March 15, 2010 involving Resident #1. Continued review of the investigation revealed Resident #1 was involved in an incident dated March 7, 2010. According to the internal investigation, the staff reported Resident #1 was unable to stand on his own and his speech was slurred after dinner on the aforementioned date. The investigation also indicated that the direct care assistant called the GHMRP's "on-call person" to report Resident #1's medical condition. Further review of the investigation and interview with the Program Director on October 27, 2010 at approximately 10:31 a.m., revealed that she was the on-call person that received the call. According to the Program Director, she contacted the GHMRP's nurse who instructed her that the resident should be transported to the emergency room. The investigation revealed the on-call person (Program Director) transported the resident to the emergency room at 7:30 p.m. on that evening. At the time of the survey, the Program Director verified that she transported Resident #1 to the emergency room for further evaluation and the resident's discharge diagnoses was that of a stroke. On October 27, 2010 at approximately 11:52 a.m., Resident #1's medical record was reviewed. A nursing progress note dated March 7, 2010, at 11:00 a.m., revealed Resident #1 complained of feeling dizzy after breakfast on the aforementioned date. Interview with the Program Director on the October 27,2010 at approximately 11:52 a.m. revealed that the resident had been monitored for dizziness for several weeks but no problems had been reported.	I 500	The history of dizziness dates TO May 2009. He was taken to PCP. Because doctor noted arrhythmia, she referred him TO cardiologist on 6/3/09 for "evaluation of dizzy spells." Extensive workup, including EKG and 2 week Holter event monitor Sent again 7/1/09. Dr. found no cardiac dx for dizziness and said "I would not restrict him." Therefore, episodes of dizziness were not treated as emergencies but documented and reviewed at PCP visits. Care given at reports of dizziness was to make sure he was seated and stable until dizziness passed. Dizziness continued but much less frequently. Re the evening of the stroke, he was taken	

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I 500	Continued From page 9 Review of Resident #1's medical record on October 28, 2010 at approximately 10:08 a.m. revealed a physician's order dated "As of 9/28/10." According to the physician's order, the resident diagnoses included Chronic Obstructive Pulmonary Disease(COPD), Non-Hodgkin's Lymphoma, Degenerative Joint Disease, Hypertension and Bowel Obstruction. Additionally, Resident #1 receives nebulizer treatments, and his blood pressure is monitored on a monthly basis. At the time of the survey, the facility failed to ensure Resident #1 received prompt adequate medical attention. 2. On October 27, 2010 at approximately 10:52 a.m., a form entitled "View Consumer Incident Form" was reviewed. According to the report Resident #1 was involved in another incident on January 6, 2010. Further review of the report revealed the resident had complained of leg pain in his calf. Although Resident #1 was seen by his Primary Care Physician (PCP) on January 4, 2010, he was transported to the emergency room and diagnosed with Baker's Cysts (swelling caused by fluid from the knee joint protruding to the back of the knee). Review of Resident #1's medical record on October 27, 2010 at approximately 10:55 a.m. revealed the following Nursing Progress Notes: December 31, 2009 - Resident complaining of leg pain; January 1, 2010 - "Still complaining of leg pain" January 2, 2010 - "Tried to see Dr., but because there was construction at Columbia Rd. Health Center, it was closed. Still complaining of a little	I 500	immediately To the ER. Symptoms of un-steadiness were similar to other occasions when he has had COPD exacerbations. AT ER, after admission, CT scan revealed a stroke. In future, given that he now has a confirmed stroke should he exhibit symptoms of a stroke, he will be transported by ambulance Inspection was provided sign in sheet for training, staff received in S/S + Symptoms of stroke. 3523.1 2. The individual expressed pain in leg on 12/31. Since it was not an emergency (no symptoms requiring calling an ambulance) the pain was monitored. As noted by inspection,	

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I 500	Continued From page 10 leg pain." January 3, 2010 - "Still complaining about pain in his left calf." January 4, 2010 - "Seen by Dr., pain reliever prescribed every 6 hours, monitor for swelling, elevate with heat 3 times daily. Return to Dr. if pain worsens." Resident #1 was experiencing pain in his leg from December 31, 2009 until January 4, 2010 (five days) before he received medical attention. At the time of the survey, the facility failed to ensure Resident #1 received prompt adequate medical attention.	I 500	on 1/2/10 it was "a little" He was seen at next available appt., which was Jan 4. Report from doctor reads "Would monitor for swelling, erythema, worsening pain or warmth by wrapping, would return." She did not view it as emergency and ordered OTC pain med., put heat on leg + elevate, which was done. He received prompt medical attention - next available appt. at his PCP. Only other alternative was ER. He did not have symptoms warranting that (as noted by PCP).	